EPI-LOG

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.
Epidemiology, Prevention Division
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What's New in Hepatitis Reporting?

Prior to September 2000, Public Health-Seattle & King County (Public Health) encouraged reporting of cases of hepatitis C (HCV) and chronic hepatitis B (HBV), but such reports were not mandatory. As of September 2000, however, changes to reporting requirements for notifiable conditions have made cases of **chronic hepatitis B (HBV) and all cases of hepatitis C (HCV)** ***legally notifiable conditions*** by health care providers (not laboratories) according to Washington Administrative Code (WAC 246-101).

The primary reason for adding hepatitis C and chronic hepatitis B to the list of legally notifiable conditions is to get a more accurate picture of the prevalence of these diseases in Washington. Having a better understanding of the burden of chronic hepatitis in our community will help Public Health in obtaining resources for hepatitis prevention programs including education, counseling, testing and referral services for persons at risk for, or already infected with, chronic viral hepatitis.

Cases of HCV and chronic HBV can be reported *by health care providers* to Public Health – Seattle & King County on a monthly basis. **Cases are to be reported a) at the time of initial diagnosis, or b) for previously-diagnosed unreported cases, when follow-up testing for chronic hepatitis is obtained after September 2000.** Reporting of hepatitis C cases should include persons who have detectable antibody to HCV (anti-HCV positive) and/or persons who have detectable HCV RNA, either by a qualitative or a quantitative test. If you are uncertain if a case has already been reported, proceed with reporting when new hepatitis testing has been ordered. If the case has already been reported, the case will be updated if there is new information.

The only exception to monthly reporting of chronic HBV is for pregnant women who are HBsAg-positive; these cases should be reported within **3 work days**. Screening for HBsAg is recommended for all pregnant women during each pregnancy, and women who are HBsAg-positive should be reported to Public Health during each pregnancy. Women who are HBsAg-positive are enrolled in a confidential tracking and reminder system to assure that their infant receives timely and necessary post-exposure treatment (HBIG and the first dose of hepatitis B vaccine within 12 hours of birth, and the second and third doses of vaccine at 1-2 months and just after 6 months of age).

Suspected or confirmed cases of acute HBV (and unspecified hepatitis suspected to be from an infectious source) are also reportable *by health care providers* within **3 work days**.

Suspected or confirmed cases of hepatitis A are reportable to Public Health *by health care providers* **immediately**. This is particularly critical for cases working as food handlers, where a greater potential risk to the public exists.

Whenever possible, the following information should be included in your initial report of confirmed or suspected cases of viral hepatitis:

1. Case demographic information: name, birthdate, address, telephone number, race and gender.
2. Laboratory results: date blood drawn, results of **all** hepatitis markers and liver function tests, if done, not just abnormal results.
3. Clinical information: reason for testing, clinical symptoms and date of onset of hepatitis, whether the case is a known HBV or HCV "carrier".
4. Risk factor information: injection drug use, blood or blood product exposure, sexual exposure, close contact with a known case.
5. Health care provider's information: name, address, and telephone number.
6. Pregnancy status of females aged 12-52 years who are HBsAg-positive (or date of last menstrual period, if known).

Reporting of hepatitis and other notifiable conditions to Communicable Disease Control and Epidemiology can be done by:

1) **calling 206-296-4774 between 8 am - 5pm,**
2) **calling our 24-hour report line at 206-296-4782,**
3) **faxing a copy of the test results along with case report information to our confidential fax at 206-296-4803, or**
4) **for chronic cases only, mailing a copy of the test results to our office.**

For a list of current notifiable conditions, you can call 206-296-4774. For the complete document of legally notifiable conditions, go to the following URL: http://www.doh.wa.gov/OS/Policy/246-101prp3.pdf. For questions about reporting of suspected or confirmed hepatitis cases, contact Shelly McKeirnan, 206-296-4717. For questions about reporting of HBsAg-positive pregnant women contact Linda Vrtis, 206-296-4777.

Corrections to List of Notifiable Diseases and Report of Notifiable Diseases – July

The revised list of officially Notifiable Diseases for the State of Washington, published in last month's Epi-Log, failed to list Invasive Group A Streptococcal Disease as reportable *by health care providers* within **3 work days**. Rocky Mountain Spotted Fever has been dropped from the list of Notifiable Diseases. Animal bites from rodents are not reportable. Also, the table of reported cases of selected diseases in the August issue of the Epi-Log was incorrect. A corrected table is on-line at: http://www.metrokc.gov/health/phnr/prot_res/

Public Health Endorses Smear Tactics!

On a Friday in July, a ten year-old King County boy complained to his mother of headache and malaise, and had a temperature of 101°. His mother treated him with acetaminophen and cool showers, thinking he

probably had a mild viral illness. The next morning, however, when his temperature climbed to 104° and he reported a severe headache in spite of the acetaminophen therapy, she took him to urgent care. There, as part of his history, she informed the health care provider that he had just acquired a new puppy and had just returned from two weeks at a camp in Coeur d'Alene, Idaho. The boy's temperature at urgent care was 103°. He was examined, rehydrated, a CBC and urinalysis was taken, and he was discharged.

On Sunday morning the boy's temperature had returned to 104° and he still complained of a crushing headache, so he and his mother returned to urgent care. By the time he was seen his temperature had fallen to 98° and he was discharged with a diagnosis of "probably a virus".

On Monday morning, his temperature had again risen to 104°, and he was taken to his regular physician's office. Radiographs were taken to rule out appendicitis, but he was unable to stand and was hospitalized at a local children's' hospital. The laboratory for the urgent care was called to obtain results of the previous blood work, and they reported what appeared to be a spirochete on his blood film. Treatment for tick-borne relapsing fever was initiated, the boy experienced a mild Jarisch-Herxheimer reaction, and recovered uneventfully.

Tick-borne relapsing fever (TBRF) is a treatable endemic disease within the northwestern United States. Cases originating in this part of the country are caused by a spirochete, *Borrelia hermsii*, which is transmitted by the bites of soft (argasid) ticks of the Ornithodoros family. The natural reservoirs of the spirochete are members of the rodent family. Unlike the hard *Ixodes* tick that transmits Lyme disease, argasid ticks are night-feeders with a painless bite, and the infection does not cause a "bulls-eye" erythema migrans lesion. Because they do not attach to the victim for a feed of several days, checking the body well for ticks (as people are advised
to do to prevent Lyme disease) will not eliminate the risk of TBRF. These argasid ticks are most often encountered when people occupy cabins or other seasonal buildings that harbor rodents, which in turn harbor argasid ticks in the nest. The ticks can live for several years between blood meals while remaining infectious, and when unused buildings are inhabited, the tick responds to the increased warmth and carbon dioxide to seek out and feed on occupants. Cases peak in the spring and summer, but cases do occur all year-round as people re-occupy unused residences. The incubation period of TBRF is 7-18 days (mean = 7 days).

TBRF is believed to be under-diagnosed and under-reported. The primary symptoms of TBRF are high fever, headache, myalgia, arthralgia, nausea, vomiting and thrombocytopenia. More than 50% of cases will have a fever of over 104°, and many, like the case described above, suffer several relapses before diagnosis despite seeking medical attention. The diagnostic standard is presence of spirochetes in peripheral blood smears, but these are only observed when a manual review of a peripheral blood smear is performed.

It is recommended that a manual review of a peripheral blood smear be obtained for a flu-like illness with a history of potential exposure to Ornithodoros ticks. Spirochetes are found in 70% of cases when wet blood smears are examined by darkfield microscopy or in Giemsa- and Wright-stained thick and thin smears collected during febrile periods. While serological testing is available, its cross-reactivity with other Borrelias, such as the Lyme disease spirochete *B. burgdorferi*, makes it less useful than examination of the blood smear. TBRF responds to treatment with penicillins, tetracycline, and erythromycin.

Disease Reporting (area code 206)
AIDS……296-4645
Communicable Disease…296-4774
STDs……..731-3954
Tuberculosis……731-4579
24-hr Report Line……296-4782

Hotlines:
CD Hotline……296-4949
HIV/STD Hotline……..205-STDS

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http://www.metrokc.gov/health

Reported Cases of Selected Diseases Seattle-King County 2000

	Cases Reported In August		Cases Reported Through August	
	2000	1999	2000	1999
VACCINE-PREVENTABLE DISEASES				
Mumps	4	0	8	1
Measles	0	0	2	1
Pertussis	10	15	146	394
Rubella	0	0	1	2
SEXUALLY TRANSMITTED DISEASES				
Syphilis	8	4	55	53
Gonorrhea	109	74	718	599
Chlamydial infections	531	344	3061	2512
Herpes, genital	59	44	550	443
Pelvic Inflammatory Disease	27	22	161	177
Syphilis, late	1	10	16	29
Syphilis, congenital	1	0	1	0
ENTERIC DISEASES				
Giardiasis	19	17	151	121
Salmonellosis	24	22	151	211
Shigellosis	13	4	128	39
Campylobacteriosis	43	34	229	188
E.coli O157:H7	7	6	38	26
HEPATITIS				
Hepatitis A	12	20	76	123
Hepatitis B	4	5	30	28
Hepatitis C/non-A, non-B	0	2	6	5
AIDS	18	15	159	146
TUBERCULOSIS	10	10	77	65
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae B (cases < 6 years of age)	0	1	0	1
Meningococcal disease	1	4	11	17